OrthoWest (Dr. Hahn) New Patient Questionnaire

Date: _____

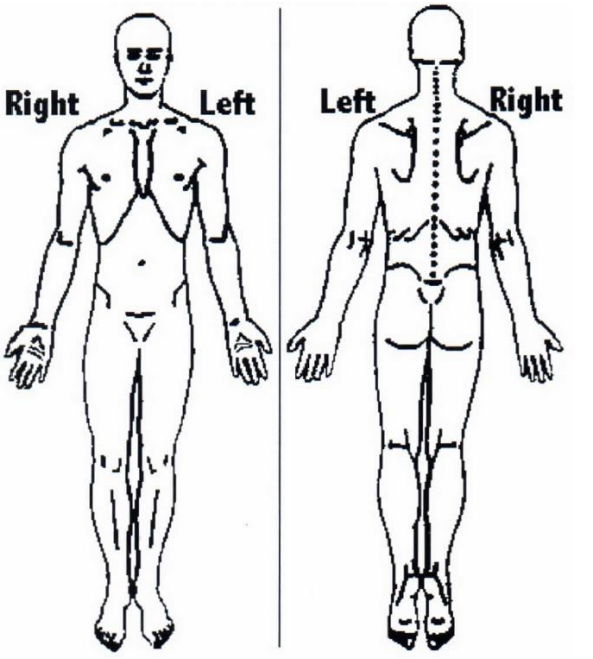
Name: _____

Primary Care Physician: _____

Referring Physician: _____

What is the main reason for today's visit? _____

1. On the diagram to the right, please place an "X" where your pain starts.
2. If your pain radiates, draw an arrow on the diagram over the area the pain radiates.
3. When did your original injury occur?
   Date: __/__/____
4. Please describe your injury in as much detail as possible:



5. Did your pain start (circle one):
   Suddenly / Gradually
6. Have your symptoms been (circle one):
   Improving / Unchanged / Worsening
7. Are your symptoms (circle one):
   Constant / Intermittent
8. Circle the most consistent descriptors below that describe your pain:
   Sharp / Dull / Achy / Burning / Numbness / Tingling / Cramping / Stiff
9. What makes your pain worse:
   Sitting / Standing / Walking / Lying down / Bending / Exercise / Other:_____
10. What is your pain today on a scale of 0-10 (0 meaning no pain; 10 meaning the worst imaginable pain)?
    0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 pain
11. What is your pain at its worst on a scale of 0-10?
    0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 pain
12. What is your pain at its best on a scale of 0-10?
    0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 pain
13. What is your pain on an average day on a scale of 0-10?
    0 --- 1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 pain

14. Have you experienced:

Fevers:	YES	NO	
Weight loss:	YES	NO	
Vision changes:	YES	NO	
Headaches:	YES	NO	
Chest pain:	YES	NO	
Shortness of breath:	YES	NO	
Loss of bowel control:	YES	NO	
Loss of bladder control:	YES	NO	
Rashes:	YES	NO	
Weakness:	YES	NO	If yes, where: _____
Numbness and/or Tingling:	YES	NO	If yes, where: _____
Depressed mood:	YES	NO	
Anxiety:	YES	NO	
Sleep problems:	YES	NO	
Other joint swelling:	YES	NO	
Pregnant or breast feeding:	YES	NO	

15. Is there litigation pending on this injury: YES NO
16. Was this injury a result of a motor vehicle accident? YES NO
17. Was this injury work related? YES NO

18. Do you have an allergy or adverse reaction to:

Contrast:	YES	NO
If yes, describe the reaction: _____		
Iodine:	YES	NO
If yes, describe the reaction: _____		
Betadine:	YES	NO
If yes, describe the reaction: _____		
Lidocaine:	YES	NO
If yes, describe the reaction: _____		
Steroids:	YES	NO
If yes, describe the reaction: _____		

19. Do you take any of the following medications:

Coumadin (warfarin)	YES	NO
Aspirin 325 mg	YES	NO
Plavix (clopidogrel)	YES	NO
Effient (prasugrel)	YES	NO
Pradaxa (dabigatran etexilate)	YES	NO
Eliquis (apixaban)	YES	NO
Aggrenox (aspirin/dipyridamole)	YES	NO
Trental (pentoxifylline)	YES	NO
Xarelto (rivaroxaban)	YES	NO
Glucophage (metformin)	YES	NO
Janumet (sitagliptin/metformin)	YES	NO

20. Have you ever had any of the following diagnostic studies to evaluate your injury (please bring reports and images to your clinic visit for review by the physician):

X-Rays:	YES	NO
Date completed: __/__/____		
Results:		
MRI:	YES	NO
Date completed: __/__/____		
Results:		
EMG:	YES	NO
Date completed: __/__/____		
Results:		

21. Please list any of the following treatments that you have had for this injury:

Physical therapy: YES NO
If yes, when and where? _____

Chiropractor: YES NO
If yes, when and where? _____

Acupuncture: YES NO
If yes, when and where? _____

Massage: YES NO
If yes, when and where? _____

Other: YES NO
If yes, what, when and where? _____

Pain medications:
Medication: _____ Dose: _____ Frequency: _____ Helpful: YES/NO

Medication: _____ Dose: _____ Frequency: _____ Helpful: YES/NO

Medication: _____ Dose: _____ Frequency: _____ Helpful: YES/NO

Medication: _____ Dose: _____ Frequency: _____ Helpful: YES/NO

Medication: _____ Dose: _____ Frequency: _____ Helpful: YES/NO

Previous Surgeries:
Surgeon: _____ Date of surgery: __/__/____
Name and location of surgery performed: _____

Surgeon: _____ Date of surgery: __/__/____
Name and location of surgery performed: _____

Surgeon: _____ Date of surgery: __/__/____
Name and location of surgery performed: _____

Previous Injections:
Physician: _____ Date of surgery: __/__/____
Name and location of injection performed: _____

Physician: _____ Date of surgery: __/__/____
Name and location of injection performed: _____

Physician: _____ Date of surgery: __/__/____
Name and location of injection performed: _____

Thank you very much for your time. This information may be helpful in diagnosing and managing your health care concerns.